



Hormone Replacement Recommendation

Fax to: 1-877-890-8435

***Need recommendation for:** PELLETS DROPS CREAM TROCHE RDT INJECTIONS

Provider: _____ **Phone:** _____ **Fax:** _____ **Date:** _____

Patient Name: _____ **DOB:** _____ **Phone:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Height: _____ **Weight:** _____ **Medication History:** _____

FEMALE **Date of lab results:** _____

Lab results

Symptoms

- FSH _____ Hot flashes
- Estradiol _____ Night sweats
- Estrone _____ Moodiness
- Progesterone _____ Depression
- Testosterone _____ Sleepless nights
- TSH _____ Fatigue
- T3 Free _____ Low sex drive
- T4 Free _____ Weight gain
- Cortisol _____ Poor cognitive function
- SHBG _____ Vaginal dryness

Past Medical History

- Hysterectomy: YES NO **Date:** _____
- Oophorectomy: YES NO **Date:** _____
- Date of last period:** _____
- Are you currently on hormone replacement?**
- YES NO
- If so, what type?** _____
- Do you smoke?** YES NO
- If so, how much?** _____

Have you or a family member had the following

- Breast cancer **Who?** _____
- Uterine cancer **Who?** _____
- Ovarian cancer **Who?** _____
- Osteoporosis **Who?** _____
- Uterine fibroids **Who?** _____
- Cancer of any kind **Who?** _____
- If other, what kind?** _____

MALE **Date of lab results:** _____

Lab results

Symptoms

- Total testosterone _____ Hot flashes
- Free testosterone _____ Moodiness
- Estradiol _____ Depression
- PSA _____ Loss of muscle
- TSH _____ Easy to lose erection
- T3 Free _____ Fatigue
- T4 Free _____ Poor cognitive function
- Hematocrit _____ Frequent urination
- Hemoglobin _____ Low sex drive
- SHBG _____

Past Medical History

- Have you ever used Testosterone replacement?**
- YES NO
- If so, when** _____ **what type?**
- _____
- Do you smoke?** YES NO
- If so, how much?** _____

Have you or a family member had the following

- Prostate cancer **Who?** _____
- Prostatitis **Who?** _____
- Cancer of any kind **Who?** _____
- If other, what kind?** _____

Date of last pellet insertion: _____ **Dose given:** Estradiol _____mg Testosterone _____mg
Patient has appointment for pellets on: _____